

# **Drug Medi-Cal Billing Manual**

Program Services Division

Fiscal Management and Accountability  
Branch

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**DRUG MEDI-CAL BILLING MANUAL**

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# **1. INTRODUCTION**

## 1 Introduction

This manual provides information for counties and providers contracting with the California Department of Alcohol and Drug Programs (ADP) regarding the submission of claims for Drug Medi-Cal (DMC) services rendered by certified DMC providers as required by California Health and Safety Code Section 11758.46(c)(1).<sup>1</sup>

- [Definitions of Key Terms](#)
- [About This Manual](#)
- [Program Background and Authorities](#)
- [DMC Beneficiaries](#)
- [DMC Services](#)

### 1.1 Definitions of Key Terms

The following terms are relevant to the information provided in this chapter and this manual:

- **County:** A county that submits DMC claims for their own DMC certified county operated programs or DMC certified county contracted programs. ADP primarily contracts with counties (who in turn operate and/or contract with providers) for DMC services.<sup>2</sup>
- **Direct Provider (DP):** A DMC certified alcohol and other drug service provider that contracts directly with ADP and submits DMC claims directly to ADP.
- **Trading partners:** Counties and DPs that submit DMC claims.
- **Covered Entity:** According to the Administrative Simplification standards adopted by the U.S. Dept. of Health & Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA),<sup>3</sup> a covered entity is:<sup>4</sup>
  - a health care provider that conducts certain transactions in electronic form
  - a health care clearinghouse, or
  - a health plan

Additional helpful information about determining covered entity status can be found on the “Are You a Covered Entity?” page of the U.S. Dept. of Health & Human Services Centers for Medicare & Medicaid Services website.<sup>5</sup>

<sup>1</sup> Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46 (2008).

<sup>2</sup> Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.40 (2008).

<sup>3</sup> Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104<sup>th</sup> Cong., 2<sup>nd</sup> sess., (Aug. 21, 1996).

<sup>4</sup> 45 C.F.R., subtitle A, part 162 (current through current through Oct. 1, 2008).

<sup>5</sup> U.S. Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, “Are You a Covered Entity?” [http://www.cms.hhs.gov/HIPAAGenInfo/06\\_AreYouaCoveredEntity.asp](http://www.cms.hhs.gov/HIPAAGenInfo/06_AreYouaCoveredEntity.asp) (accessed April 29, 2009).

## 1.2 About This Manual

### 1.2.1 Objectives

The objectives of the manual are to:

- Provide uniform guidance to ADP trading partners on DMC billing procedures and requirements
- Provide references to documents and sources containing information useful to ADP trading partners, including:
  - Relevant California and federal laws and regulations
  - ADP Bulletins and ADP Letters<sup>6</sup>
  - Other relevant reference documents

### 1.2.2 Scope

This manual provides information about processes and procedures related to DMC billing. For detailed information on the format and content of the electronic claims, remittance advices, status request/response transactions and unsolicited claims status used in the DMC billing process, consult the companion guides posted on the “HIPAA Privacy and Security” page of the ADP website.<sup>7</sup> The companion guides supplement the information in the corresponding Accredited Standards Committee (ASC) X12N Implementation Guides.

## 1.3 Program Background and Authorities

### 1.3.1 Medicaid Program

Medicaid is a federal program established in 1965 as Title XIX of the Social Security Act designed to enable states to furnish medical assistance to families with dependent children, as well as aged, blind, and disabled individuals who lack the financial means to meet the cost of necessary medical services, and to provide rehabilitative and other services to such families and individuals.<sup>8</sup> Under Medicaid, each participating state must establish a state plan for medical assistance possessing certain mandatory features.<sup>9</sup> The federal government pays a portion of the eligible costs of covered services (the Federal Medical Assistance Percentage or FMAP) with the remainder paid by the state.<sup>10</sup> FMAP is calculated annually by state based on the *per capita* income of the

<sup>6</sup> Cal. Dept. of Alcohol and Drug Programs, “Bulletins & Letters,” [http://www.adp.ca.gov/ADPLTRS/bulletin\\_letter.shtml](http://www.adp.ca.gov/ADPLTRS/bulletin_letter.shtml) (accessed April 29, 2009).

<sup>7</sup> Cal. Dept. of Alcohol and Drug Programs, “HIPAA Privacy & Security,” <http://www.adp.ca.gov/hp/hipaa.shtml> (accessed April 29, 2009).

<sup>8</sup> 42 U.S.C. chap. 7, subchap. XIX, §1396-1396v (current through Jan. 3, 2007).

<sup>9</sup> 42 U.S.C. chap. 7, subchap. XIX, §1396a(a) (current through Jan. 3, 2007).

<sup>10</sup> 42 U.S.C. chap. 7, subchap. XIX, §1396(b) (current through Jan. 3, 2007).

state compared to that of the United States as a whole. FMAP data is provided online by the U.S. Department of Health and Human Services.<sup>11</sup>

### 1.3.2 *California Medical Assistance Program (Medi-Cal)*

Medi-Cal, administered by the Department of Health Care Services (DHCS), includes California's participation in the federal Medicaid program.

### 1.3.3 *Drug Medi-Cal*

With the broader Medi-Cal program, ADP administers the Drug Medi-Cal Treatment program also known as Drug Medi-Cal (DMC). DMC reimbursement is issued to counties and direct providers that have a contract with ADP for approved DMC services provided to medi-cal beneficiaries.

#### 1.3.3.1 *Privacy, Security, and Confidentiality and DMC Client Information*

The federal Public Health Service Act and related regulations provide for strict confidentiality of patient records in substance use programs, including the DMC program, allowing disclosure only in specific circumstances and providing for criminal penalties for violations.<sup>12</sup>

In addition, HIPAA and the regulations implementing it have established rules to ensure the privacy and security of all patient medical records (not just those of patients in substance use programs).<sup>13</sup>

The privacy rule prohibits the use and disclosure of protected health information (PHI) by health plans, health care providers, and other covered entities except as specifically permitted.<sup>14</sup> Even for purposes where use or disclosure of PHI is permitted, the rule in most cases requires that the covered entity "make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose."<sup>15</sup>

The security rule requires each covered entity to "(1) Ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity creates, receives, maintains, or transmits," to "(2) Protect against any reasonably anticipated threats or hazards to the security or integrity of such information," to "(3) Protect against any reasonably anticipated uses or disclosures of such information that are not permitted [...]" and to ensure compliance with the security rule by the entity's workforce.<sup>16</sup>

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<sup>11</sup> U.S. Dept. of Health & Human Services, "Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures (FMAP)," <http://aspe.hhs.gov/health/fmap.htm> (accessed April 29, 2009).

<sup>12</sup> 42 U.S.C. §290dd-2 (current through Jan. 3, 2007); 42 C.F.R. part 2 (current through Oct. 1, 2008).

<sup>13</sup> Id. at §264; 45 C.F.R. part 164, subpart C (§164.302 *et seq.*) [security rule], and 45 C.F.R. part 164, subpart E (§164.500 *et seq.*) [privacy rule] (current through Oct. 1, 2008).

<sup>14</sup> 45 C.F.R., subtitle A, vol. 1, part 164, §164.502(a) (current through Oct. 1, 2008).

<sup>15</sup> 45 C.F.R., subtitle A, vol. 1, part 164, §164.502(b)(1) (current through Oct. 1, 2008).

<sup>16</sup> 45 C.F.R., subtitle A, vol. 1, part 164, §164.306(a) (current through Oct. 1, 2008).

The security rule provides a number of implementation specifications that covered entities are required to fulfill. Some require implementation. Others require assessment and implementation when reasonable and appropriate for the particular environment or adoption of an equivalent alternative measure if one exists plus documentation of the reasons why it is not reasonable and appropriate.<sup>17</sup>

ADP-certified DMC providers should read ADP's "Confidentiality Statement for DMC Patient Data."<sup>18</sup> Additional information and resources regarding HIPAA rules is available from ADP's "HIPAA, Privacy and Security" web page.<sup>19</sup>

### 1.3.3.2 Health Care Transactions and Code Sets

HIPAA and its implementing regulations also require that every covered entity that performs specified business transactions electronically must use specified standard transactions, code sets, and identifiers.<sup>20</sup> The transactions which ADP, in the DMC program, conducts electronically for which standard transactions exist and the applicable standards are:

- Professional health care claims (all DMC claims): ASC X12N 837—Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098, and Addenda to Health Care Claims: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1.<sup>21</sup>
- Health Care Claim Status (electronic requests for DMC claim status and the responses to such requests): ASC X12N 276/277—Health Care Claim Status Request and Response, Version 4010, May 2000, Washington Publishing Company, 004010X093, and Addenda to Health Care Claim Status Request and Response, Version 4010, October 2002, Washington Publishing Company, 004010X093A1.<sup>22</sup>
- Health Care Remittance Advice (provides information on DMC payments and denied DMC claims): The ASC X12N 835—Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A1.<sup>23</sup>

The companion guides posted on the ADP website supplement the information in the corresponding ASC X12N Implementation Guides.<sup>24</sup>

<sup>17</sup> 45 C.F.R., subtitle A, vol. 1, part 164, §164.306(d) (current through Oct. 1, 2008).

<sup>18</sup> Cal. Dept. of Alcohol and Drug Programs, "Confidentiality Statement for Drug Medi-Cal Patient Data," <http://www.adp.ca.gov/dmc/pdf/confidentiality.pdf> (accessed April 29, 2009).

<sup>19</sup> Cal. Dept. of Alcohol and Drug Programs, "HIPAA Privacy & Security," <http://www.adp.ca.gov/hp/hipaa.shtml> (accessed April 29, 2009).

<sup>20</sup> 45 C.F.R., subtitle A, vol. 1, part 162, §162.923 (current through Oct. 1, 2008).

<sup>21</sup> 45 C.F.R., subtitle A, vol. 1, part 162, §162.1102(b)(3) (current through Oct. 1, 2008).

<sup>22</sup> 45 C.F.R., subtitle A, vol. 1, part 162, §162.1402(b) (current through Oct. 1, 2008).

<sup>23</sup> 45 C.F.R., subtitle A, vol. 1, part 162, §162.1602(b) (current through Oct. 1, 2008).

<sup>24</sup> <sup>24</sup> Cal. Dept. of Alcohol and Drug Programs, "HIPAA Privacy & Security," <http://www.adp.ca.gov/hp/hipaa.shtml> (accessed April 29, 2009).



Each standard transaction implementation specification identifies the code sets which are used in the transaction. The Healthcare Common Procedure Coding System (HCPCS) used to identify clinical procedures,<sup>25</sup> and the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) used to identify diagnoses, are important code sets used in standard transactions.

Standard identifiers are used to identify individuals or organizations on standard transactions. The two standard identifiers mandated under HIPAA rules are the National Provider Identifier (NPI) as the standard unique health identifier for health care providers<sup>26</sup> and the Employer ID Number (EIN)<sup>27</sup> as the standard unique employer identifier.<sup>28</sup>

The use of these identifiers in standard transactions is mandatory. Entities entering into DMC contracts with ADP must have an EIN and all DMC-certified providers must have an NPI for each certified location including satellite locations. Individual service providers such as counselors who are identified on standard transactions (for example as rendering providers) must also have NPIs. Both EINs and NPIs must be provided to ADP.

## 1.4 DMC Beneficiaries

Clients who are eligible for Drug Medi-Cal services include clients eligible for federal Medicaid, for whom services are reimbursed from federal and state funds, and clients eligible for state-only Medi-Cal, for whom services are reimbursed from state funds only.

Clients may establish Medi-Cal eligibility through a number of Medi-Cal programs, and are assigned Aid Codes based on the program(s) under which they have established eligibility.<sup>29</sup>

### 1.4.1 Aid Codes

The ADP Aid Code list provides useful information including:<sup>30</sup>

- Aid Code and description
- Type of benefits
- Share of Cost, if any
- Federal Financial Participation (FFP) type

<sup>25</sup> U.S. Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, "HCPCS General Information," <http://www.cms.hhs.gov/MedHCPCSGenInfo> (accessed April 29, 2009).

<sup>26</sup> 45 C.F.R., subtitle A, vol. 1, part 162, §162.406 (current through Oct. 1, 2008).

<sup>27</sup> Also known as the Federal Tax Identification Number, see U.S. Department of the Treasury, Internal Revenue Service. "Employer ID Numbers (EINs)," January 27, 2009.

<http://www.irs.ustreas.gov/businesses/small/article/0,,id=98350,00.html> (accessed March 30, 2009).

<sup>28</sup> 45 C.F.R., subtitle A, vol. 1, part 162, §162.605 (current through Oct. 1, 2008).

<sup>29</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 2, art. 5 (§50201 *et seq.*) (current through March 6, 2009).

<sup>30</sup> Aid Code List [http://www.adp.ca.gov/pdf/ADP\\_Aid\\_Codes\\_Master\\_Chart.pdf](http://www.adp.ca.gov/pdf/ADP_Aid_Codes_Master_Chart.pdf)

#### 1.4.2 *Beneficiaries with Minor Consent eligibility*

Currently, the only clients eligible for DMC services under the state-only Medi-Cal program are those beneficiaries that have minor consent eligibility and have assigned Aid Codes 7M, 7N, and 7P. Minor Consent services are services to which a minor may consent independently and confidentially under various provisions of California law and for which their parent(s) or guardians are not held financially responsible.<sup>31</sup>

#### 1.4.3 *Beneficiaries with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligibility*

Medicaid-eligible clients under 21 years of age are also eligible under the EPSDT program, and as such are eligible for DMC services and other Medi-Cal services for which other youth may not be eligible.<sup>32</sup>

### 1.5 **DMC Services**

The following services may be reimbursed from DMC funds when provided in accordance with the laws and regulations governing the DMC program.

#### 1.5.1 *Narcotic Treatment Program (NTP) Services*

“Narcotic treatment program services, utilizing methadone and/or levoalphacetyl-methadol (LAAM) as narcotic replacement drug, including intake, treatment planning, medical direction, body specimen screening, physician and nursing services related to substance abuse, medical psychotherapy, individual and/or group counseling, admission physical examinations and laboratory tests, medication services, and the provision of methadone and/or LAAM, as prescribed by a physician to alleviate the symptoms of withdrawal from opiates, rendered in accordance with the requirements set forth in Chapter 4 commencing with Section 10000 of Title 9, CCR.”<sup>33</sup>

However LAAM, formerly available in the United States under the brand name ORLAAM®, has been withdrawn from the market by the manufacturer and at this time is not currently produced in or imported into the United States.<sup>34</sup>

#### 1.5.2 *Outpatient Drug Free (ODF) Services*

“Outpatient drug free treatment services including admission physical examinations, intake, medical direction, medication services, body specimen screens, treatment and discharge planning, crisis intervention, collateral services, group counseling, and

<sup>31</sup> Cal. Welf. & Ins. Code, div. 9, part 3, chap. 7, art. 1, §14010 (2008).

<sup>32</sup> Cal. Dept. of Alcohol and Drug Programs, “Fact Sheet: Drug Medi-Cal (DMC) Early and Periodic Screening Diagnosis and Treatment (EPSDT),” [http://www.adp.ca.gov/FactSheets/EPSDT\\_Fact\\_Sheet\\_v4.pdf](http://www.adp.ca.gov/FactSheets/EPSDT_Fact_Sheet_v4.pdf) (accessed April 29, 2009).

<sup>33</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(1) (current through March 6, 2009).

<sup>34</sup> U.S. Food and Drug Administration, Center for Drug Evaluation and Research, “Drug Shortage: Drug to Be Discontinued, Letter from Roxane,” <http://www.fda.gov/cder/drug/shortages/orlaam.htm> (accessed April 29, 2009).

individual counseling, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure.”<sup>35</sup>

#### 1.5.2.1 ODF Group Counseling

“Group counseling sessions shall focus on short-term personal, family, job/school, and other problems and their relationship to substance abuse or a return to substance abuse. Services shall be provided by appointment. Each beneficiary shall receive at least two group counseling sessions per month.”<sup>36</sup>

#### 1.5.2.2 ODF Individual Counseling

“Individual counseling shall be limited to intake crisis intervention, collateral services, and treatment and discharge planning.”<sup>37</sup>

#### 1.5.3 Day Care Rehabilitative (DCR) Services

“Day care habilitative services including intake, admission physical examinations, medical direction, treatment planning, individual and group counseling, body specimen screens, medication services, collateral services, and crisis intervention, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure. Day care habilitative services shall be provided only to pregnant and postpartum women and/or to EPSDT-eligible beneficiaries as otherwise authorized in this Chapter. The service shall consist of regularly assigned, structured, and supervised treatment.”<sup>38</sup>

If a beneficiary is of minor consent eligibility and uses their minor consent eligibility as their primary source of medi-cal eligibility, DCR services are not reimbursable under the Drug Medi-Cal program unless they are pregnant or postpartum.

#### 1.5.4 Perinatal Residential Services

“Perinatal residential substance abuse services including intake, admission physical examinations and laboratory tests, medical direction, treatment planning, individual and group counseling services, parenting education, body specimen screens, medication services, collateral services, and crisis intervention services, provided by staff that are lawfully authorized to provide and/or order these services within the scope of their practice or licensure.”<sup>39</sup> Perinatal residential substance abuse services shall be provided in a residential facility licensed by ADP pursuant to Chapter 5 and these services are only reimbursable under the Drug Medi-Cal program only when provided in a facility with a treatment capacity of 16 beds or less, not including beds occupied by

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<sup>35</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(2) (current through March 6, 2009).

<sup>36</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(2)(A) (current through March 6, 2009).

<sup>37</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(2)(B) (current through March 6, 2009).

<sup>38</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(3) (current through March 6, 2009); note that Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46(a)(2) (current through 2008) uses the term *rehabilitative* rather than *habilitative*.

<sup>39</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(4) (current through March 6, 2009).

children of the residents.<sup>40</sup> Room and board is not reimbursable under the Drug Medi-Cal program.

### 1.5.5 Naltrexone Treatment Services

"Naltrexone treatment services including intake, admission physical examinations, treatment planning, provision of medication services, medical direction, physician and nursing services related to substance abuse, body specimen screens, individual and group counseling, collateral services, and crisis intervention services, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure."<sup>41</sup> These services are only reimbursable under the DMC program for a beneficiary who "(A) Has a confirmed, documented history of opiate addiction; (B) Is at least (18) years of age; (C) Is opiate free; and (D) Is not pregnant."<sup>42</sup>

## 1.6 Drug Medi-Cal Reimbursement Rates

The maximum reimbursement rates for each type of DMC service are set annually by ADP and disseminated in ADP bulletins.<sup>43</sup> The Statewide Maximum Allowance (SMA) for non-NTP services and Uniform Statewide Daily Reimbursement (USDR) for NTP services are developed in accordance with California Welfare and Institutions Code Section 14021.6 and Health and Safety Code Section 11758.42.<sup>44</sup>

Reimbursements for non-NTP DMC services are settled to the lower of the provider's allowable cost of rendering the services, the provider's usual and customary charge to the general public for similar services, or the SMA for the services provided.

Reimbursements for NTP DMC services are settled to the lesser of the USDR for the services provided or the provider's usual and customary charge to the general public for similar services.<sup>45</sup>

## 1.7 Drug Medi-Cal Monitoring

Pursuant to federal and state law and regulation requiring utilization review and controls for Medicaid/Medi-Cal services<sup>46</sup> ADP conducts Post Service Post Payment (PSPP) utilization reviews at DMC provider sites to determine compliance with standards of care and other DMC requirements.<sup>47</sup> PSPP reviews provide quality assurance and accountability for DMC services, assist counties and providers in identifying and

<sup>40</sup> *Ibid.*

<sup>41</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(5) (current through March 6, 2009).

<sup>42</sup> *Ibid.*

<sup>43</sup> Cal. Dept. of Alcohol and Drug Programs, "Bulletins & Letters," [http://www.adp.ca.gov/ADPLTRS/bulletin\\_letter.shtml](http://www.adp.ca.gov/ADPLTRS/bulletin_letter.shtml) (accessed April 29, 2009).

<sup>44</sup> Cal. Welf. & Ins. Code, div. 9, part 3, chap. 7, art. 1, §14021.6 (2008); Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.42 (2008).

<sup>45</sup> Cal. Code Regs., Title 22, Division 3, Subdivision 1, Chapter 3, Article 7, §51516.1(a) (current through March 6, 2009); Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46(h)(1) (2008).

<sup>46</sup> 42 U.S.C., chap. 7, subchap. XIX, §1396(a)(30)-(33) (current through Jan. 3, 2007); 42 C.F.R., vol. 4, Chapter 4, §456.2-456.6 (current through Oct. 1, 2008); 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1 (current through March 6, 2009).

<sup>47</sup> Cal. Dept. of Alcohol and Drug Programs, "Licensing," <http://www.adp.ca.gov/Licensing/index.shtml> (accessed April 29, 2009).

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resolving compliance issues, and provide opportunities for training and technical assistance to counties and providers.

At the conclusion of each PSPP review, ADP issues a written report detailing any deficiencies found and identifying recovery for any payments made for units of service which are found to be out of compliance. The county and/or provider are required to develop and implement a corrective action plan for each identified deficiency.<sup>48</sup>

Additional information about PSPP reviews can be found on ADP's "Drug Medi-Cal Monitoring" web page.<sup>49</sup>

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<sup>48</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(m)-(o) (current through March 6, 2009).

<sup>49</sup> Cal. Dept. of Alcohol and Drug Programs, Drug Medi-Cal, "DMC Provider Resource Tool-Kit Monitoring," [http://www.adp.ca.gov/dmc/dmc\\_drug\\_medical\\_monitoring.shtml](http://www.adp.ca.gov/dmc/dmc_drug_medical_monitoring.shtml) (accessed April 29, 2009).

## **2. GETTING STARTED**

## 2 Introduction

This chapter provides the requirements that must be met before submitting claims, including:

- [Licensing and Certification of DMC Providers](#)
- [Alcohol and Drug Counseling Certification](#)
- [Getting Started Once DMC Certified with Contract](#)
- [Submission and Receipt of Claims Information](#)
- [Getting Help](#)

### 2.1 Licensing and Certification of DMC Providers

The Licensing and Certification Division is responsible for assuring that quality services are provided to all program participants in a safe and healthful environment through the licensure, certification, regulation, and oversight of a statewide system of alcohol and other drug recovery and treatment facilities, programs and counselors.

#### 2.1.1 DMC Certification Requirement

In order to provide DMC services, providers must first be DMC certified by ADP. Provider certification is unique to a particular facility location, and details the DMC services which may be provided at that location. Certification also distinguishes between services which may be provided within the regular (non-perinatal) DMC program, and those which may be provided within the perinatal DMC program for substance use services for pregnant and postpartum women.<sup>50</sup> For more specific certification information, contact LCD.<sup>51</sup>

If an existing DMC certified provider intends to relocate and/or to provide other DMC services not currently certified for, the provider must be certified for the new location and/or services to provide services eligible for DMC reimbursement. DMC services are only allowed/effective beginning on the recertification date.

Applicants submitting a DMC Certification application must submit a letter to the Alcohol and Drug Program Administrator of the county in which the clinic will be located informing the county that they are submitting an application. A copy of such letter must be included in the DMC application.

Prospective applicants for DMC certification are required to attend a free DMC orientation session provided by ADP.<sup>52</sup> The orientation explains the requirements in the application process and the procedures once a provider is DMC certified. The session also serves as a source of technical assistance through the application process. Upon completion of the orientation, the applicant is issued a Certificate of Completion, which must be included in the DMC application.

<sup>50</sup> See 22 C.C.R. § 51341.1(c) regarding DMC services for pregnant and postpartum women.

<sup>51</sup> LCD may be contacted by telephone at (916) 322-2911, and provides DMC certification information on the web at [http://www.adp.ca.gov/Licensing/Drug\\_MediCal.shtml](http://www.adp.ca.gov/Licensing/Drug_MediCal.shtml).

<sup>52</sup> Contact the ADP LCD Residential and Outpatient Programs Compliance Branch (ROPCB) at (916) 322-2911.

In order to bill and receive reimbursement for DMC services,<sup>53</sup> the DMC certified providers must have a contract with either the county of where the provider site is located or directly with ADP.

### 2.1.2 *Mandatory Licensing of Residential Facilities*

Any facility which is maintained and operated to provide 24-hour, residential, non-medical, alcoholism or drug use recovery or treatment services to adults must be licensed by ADP.<sup>54</sup> Contact LCD for information regarding residential facility licensing.

### 2.1.3 *Voluntary Facility Certification*

LCD also provides a voluntary facility certification process to identify those residential and nonresidential programs that exceed minimum levels of service quality and are in substantial compliance with state program standards.<sup>55</sup> Contact LCD for information regarding voluntary facility certification.

### 2.1.4 *Licensing and Certification Documents and Forms*

License and certification forms and related documents are available from ADP's online Document Library and from LCD's "Drug Medi-Cal" web page.<sup>56</sup>

## 2.2 **Alcohol and Drug Counselor Certification**

Regulations governing certification of alcohol and other drug (AOD) counselors<sup>57</sup> require that by April 1, 2010, at least 30 percent of the staff providing counseling service in any AOD program (including any DMC program) must either be licensed or be certified by an organization approved by ADP to register and certify AOD counselors. The regulations also require any staff members that are neither licensed nor certified must be registered for certification with an organization approved by ADP to register and certify AOD counselors within six months of their date of hire.<sup>58</sup> These regulations also impose continuing education requirements on licensed and certified AOD counselors.<sup>59</sup> Contact LCD for information regarding counselor certification requirements.

<sup>53</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1 §51000.30 (current through March 6, 2009); 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 3, §51200 (current through March 6, 2009).

<sup>54</sup> Cal. Health & Safety Code §§ 11834.01–11834.02, 11834.30 (2008); 9 Cal. Code Regs., div. 4, chap. 5, subchap. 1, art. 2, §10501(a)(27) (current through March 6, 2009).

<sup>55</sup> Cal. Dept. of Alcohol and Drug Programs, Licensing, "Facility Certification," <http://www.adp.ca.gov/Licensing/certification.shtml> (accessed April 29, 2009).

<sup>56</sup> Cal. Dept. of Alcohol and Drug Programs, "Document Library," <http://www.adp.ca.gov/Library/index.shtml> (accessed April 29, 2009);

<sup>57</sup> Cal. Code Regs., tit. 9, div. 4, chap. 8 (§ 13000 *et seq.*)

<sup>58</sup> Cal. Code Regs., tit. 9, §§ 13005, 13010, 13035(f) (current through March 20, 2009).

<sup>59</sup> Cal. Code Regs., tit. 9, §§ 13015, 13055 (current through March 20, 2009).



## 2.3 Getting Started Once DMC Certified

There are several items that must be done once a provider is DMC certified in order to provide the services, bill for the services, and receive reimbursement for the services. Those items are:

### 2.3.1 *Contracts with ADP*

A county must have a signed contract with ADP to receive DMC reimbursement for their county operated DMC certified providers or their county contracted DMC certified providers.<sup>60</sup>

ADP DMC-certified providers must either have a signed, approved contract with their county or a signed, approved contract with ADP to provide, bill and receive reimbursement for DMC services.<sup>61</sup>

### 2.3.2 *Obtain National Provider Identifiers (NPIs)*

All DMC providers are required to obtain a National Provider Identifier. The NPI should be identified in the DMC application. Federal HIPAA regulations require that individual health care providers and organizations obtain NPIs. ADP Bulletin 07-04 explains how ADP expects DMC providers to use NPIs when submitting claims.<sup>62</sup> Information on requesting an NPI can be found at National Plan and Provider Enumeration System (NPPES) website.<sup>63</sup>

Once an NPI has been obtained, ADP requires trading partners to provide a copy of their NPI Certification information from NPPES to ADP in order to submit DMC claims for reimbursement.

### 2.3.3 *California Outcomes Measurement System (CalOMS) and DMC Number*

As part of the ADP licensing and certification process, each DMC-certified provider is assigned both a DMC six-digit number and a DMC number. These numbers are assigned once provider is DMC certified.

The CalOMS number is a six-digit number (the two-digit county code and a four-digit number assigned by ADP). CalOMS Treatment is a statewide client-based data collection and outcomes measurement system.<sup>64</sup> All publicly or privately funded drug treatment programs are required to submit CalOMS data to ADP.

The DMC number is a four-digit number assigned by ADP, and is used by ADP for internally purposes.

<sup>60</sup> Cal. Health & Safety Code, div. 10.5, chap. 3, §11758.20 (2008); Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.40 (2008).

<sup>61</sup> Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46(g)(1)-(2) (2008).

<sup>62</sup> Cal. Dept. of Alcohol and Drug Programs, "Bulletin 07-04," [http://www.adp.ca.gov/ADPLTRS/PDF/ADP\\_Bulletin\\_07-04.pdf](http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_07-04.pdf) (accessed April 29, 2009).

<sup>63</sup> National Plan and Provider Enumeration System <https://nppes.cms.hhs.gov/NPPES/Welcome.do> (accessed February 10, 2009).

<sup>64</sup> Cal. Dept. of Alcohol and Drug Programs, "CalOMS Treatment," <http://www.adp.state.ca.us/CalOMS/CalOMSmain.shtml>

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### *2.3.3.1 Requesting a Provider Identification Number (PIN)*

All certified DMC providers requesting verification of a client's Medi-Cal eligibility for reimbursable services must have an eight-digit Provider Identification Number (PIN) issued by Hewlett Packard (HP), formerly Electronic Data Systems (EDS).

Any certified DMC provider that has not yet received a PIN may request one by submitting a written request and faxing it to (916) 322-1176 or mailing it to:

Department of Alcohol and Drug Programs  
Fiscal Management and Accountability Branch  
1700 K Street, 4th Floor  
Sacramento, CA 95811

### *2.3.3.2 Requesting a Temporary PIN*

Temporary PINs are available for providers who do not yet have a permanent PIN or have misplaced their permanent PIN, and are only valid until midnight on the day of issuance.

Temporary PINs can only be used on the Supplemental Automated Eligibility Verification System (SAEVS) by calling 800-427-1295 to verify eligibility and perform Share of Cost (SOC) transactions. To request a temporary PIN, call the Point of Service (POS) Help Desk at (800) 541-5555.

## **2.4 Submission and Receipt of Claims Information**

All DMC claim submissions, claim status requests, solicited and unsolicited claim status information, and remittance advices detailing claim payment and denial information are exchanged between DMC trading partners and ADP through the Information Technology Web Services (ITWS) portal operated by the Department of Mental Health (DMH) using the transactions described in Chapter 1 of this manual at Section 1.3.3.2.

Each organization (DMC trading partner or vendor authorized on behalf of a DMC trading partner) using the ITWS for DMC billing purposes must designate approvers for ITWS, who are persons authorized to approve ITWS enrollment requests for staff members of that organization. Vendors authorized on behalf of a DMC trading partner must be designated as such on the trading partner's approver certification prior to designating their own approvers. Approver certification forms are available on ITWS.<sup>65</sup>

Once the organization has designated approvers for the ITWS, users who will access the ITWS must enroll (staff must enroll as users to have access to the ITWS even if they are already designated as approvers.)

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<sup>65</sup> Cal. Dept. of Mental Health ITWS, "ADP Approver Certification Forms," [https://mhhitws.cahwnet.gov/docs/public/authforms\\_adp.asp](https://mhhitws.cahwnet.gov/docs/public/authforms_adp.asp) (accessed April 29, 2009).

Appendix B of this manual provides step-by-step details on ITWS enrollment. For further information contact ADP's Fiscal Management and Accountability Branch (FMAB) at (916) 323-2043.

ITWS is a collection of web applications maintained by the DMH that allow ADP and DMH trading partners to access information securely over the Internet. Requests for access to specific areas of ITWS are approved by approvers appointed by each county director.<sup>66</sup>

## **2.5 Getting Help**

### **2.5.1 ADP Website**

The ADP website can answer many questions, and trading partners are advised to use it as a primary resource.<sup>67</sup>

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<sup>66</sup> Cal. Dept. of Mental Health ITWS, "ADP Approver Certification Forms,"

[https://mhitws.cahwnet.gov/docs/public/authforms\\_adp.asp](https://mhitws.cahwnet.gov/docs/public/authforms_adp.asp) (accessed April 29, 2009).

<sup>67</sup> Cal. Dept. of Alcohol and Drug Programs, <http://www.adp.ca.gov> (accessed April 29, 2009).

## **3. CLIENT ELIGIBILITY**

### 3 Introduction

This chapter includes information about the Medi-Cal eligibility and client financial liability. It includes:

- [Client Medi-Cal Eligibility](#)
- [Identity and Eligibility Verification Requirements](#)
- [Medi-Cal Eligibility Verification Systems](#)
- [Technical Assistance For Medi-Cal Eligibility Verification Systems](#)

#### 3.1 Client Medi-Cal Eligibility

The following sections describe Medi-Cal Eligibility Determination and Medi-Cal Identity and Eligibility Verification Requirements.

##### 3.1.1 Eligibility Determination

The determination and collection of client eligibility data typically lies with the county welfare department. Procedures for determining Medi-Cal eligibility are the responsibility of DHCS. Detailed information regarding eligibility criteria may be obtained through the DHCS website.<sup>68</sup>

Some helpful Medi-Cal eligibility concepts include:

- Client Medi-Cal eligibility data should be verified at **least monthly**.
- Clients must be eligible for Title XIX federal Medicaid reimbursement and/or 100 percent SGF Medi-Cal reimbursement.<sup>69</sup>
- Some Medi-Cal beneficiaries must meet a specified SOC for medical expenses before Medi-Cal will pay claims for services provided in that month.<sup>70</sup> SOC is determined by the county welfare department and is based on the beneficiary's or family's income and living arrangement. Members of the family may have the same or different share of cost amounts. The monthly SOC may change at any time if the individual's or family's income increases or decreases, or the family's living arrangement changes.<sup>71</sup>
- Verification of client Medi-Cal eligibility is often reviewed by external auditors after the claimed month of service. For this reason trading partners must maintain proof of client Medi-Cal eligibility in their records.
- Medi-Cal eligibility may be established retroactively through decisions resulting from court or administrative hearings.

<sup>68</sup> Cal. Dept. of Health Care Services, "Providers & Partners," <http://www.dhs.ca.gov/mcs/mcpd/meb/ACLs/Index/2007ACWDLs/10thru19.htm> (accessed April 29, 2009).

<sup>69</sup> 42 U.S.C., chap. 7, subchap. XIX, §1396-1396v (current through Jan. 3, 2007).

<sup>70</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 2 (current through March 6, 2009).

<sup>71</sup> Cal. Dept. of Alcohol and Drug Programs. "ADP Bulletin 99-39," [http://www.adp.ca.gov/ADPLTRS/PDF/ADP\\_Bulletin\\_99-39.pdf](http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_99-39.pdf) (accessed April 29, 2009).

## 3.2 Identity and Eligibility Verification Requirements

### 3.2.1 Medi-Cal Identification Cards

All Medi-Cal beneficiaries have identification cards. DHCS issues a plastic Benefits Identification Card (BIC) to each Medi-Cal beneficiary. In exceptional situations, county welfare departments may issue temporary paper identification cards for Immediate Need and Minor Consent program beneficiaries.<sup>72</sup>

All DMC claims must be submitted using the client's ID number as listed on the client's BIC or paper Medi-Cal ID card. Claims must not contain a client's social security number.<sup>73</sup>

Mere possession of a BIC is not proof of Medi-Cal eligibility because it is a permanent form of identification and is retained by the recipient even if he or she is not eligible for the current month.

### 3.2.2 Good Faith Effort to Verify Identity

It is the provider's responsibility to verify that the person is the individual to whom the BIC was issued. Identification verification should be performed prior to rendering service.

If a recipient is unknown, the provider must make a good faith effort to verify the recipient's identification before rendering Medi-Cal services. *Good faith effort* means verifying the recipient's identification by matching the name and signature on the BIC against the signature on a valid California driver's license, a California identification card issued by the Department of Motor Vehicles, another acceptable picture ID card, or other credible document of identification.<sup>74</sup>

### 3.2.3 Eligibility Review

Programs that provide DMC services are responsible for verifying the Medi-Cal eligibility of each client for each month of service prior to billing for DMC services to that client for that month. Medi-Cal eligibility verification should be performed prior to rendering service.

To verify the Medi-Cal eligibility of a client, the DMC provider must first have an eight-digit Provider Identification Number (PIN).<sup>75</sup> Refer to Chapter 2 sections 2.1.2.1 and 2.1.2.2 of this manual for details.

<sup>72</sup> Cal. Welf. & Ins. Code, Div. 9, Part 3, Chap. 7, Art. 1.3, §§14043–14045 (current through 2008); Cal. Dept. of Alcohol and Drug Programs, Bulletin 08-01, [http://www.adp.ca.gov/ADPLTRS/PDF/ADP\\_Bulletin\\_08-01.pdf](http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_08-01.pdf) (accessed April 29, 2009).

<sup>73</sup> Cal. Welf. & Ins. Code, div. 9, part 3, chap. 7, art. 1.3, §§14043–14045 (2008); Cal. Dept. of Alcohol and Drug Programs, "Bulletin 08-01," [http://www.adp.ca.gov/ADPLTRS/PDF/ADP\\_Bulletin\\_08-01.pdf](http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_08-01.pdf) (accessed April 29, 2009).

<sup>74</sup> Cal. Dept. of Health Care Services, "Eligibility: Recipient Identification Cards," Dec. 2006, [http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/eligreccrd\\_z01.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/eligreccrd_z01.doc) (accessed April 29, 2009).

<sup>75</sup> Cal. Dept. of Health Care Services, Medi-Cal, "FAQs," <http://files.medi-cal.ca.gov/pubsdoco/faq.asp> (accessed April 29, 2009).

### 3.3 Medi-Cal Eligibility Verification Systems

The three options for verifying the eligibility of a Medi-Cal beneficiary are described in the following sections.

#### 3.3.1 Automated Eligibility Verification System (AEVS)

The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows providers having a valid PIN to access recipient eligibility via a touch-tone telephone. User instructions and other information regarding the AEVS are available in the *DHCS AEVS User Guide*.<sup>76</sup> Providers should document and retain the Eligibility Verification Confirmation returned by AEVS in the client's file to document eligibility verification.

#### 3.3.2 Point of Service (POS) Device

The POS device is an automated transaction device which allows checking eligibility by swiping the client's BIC or by manually entering information. Use instructions and other information regarding the AEVS are available in the *DHCS Point of Service (POS) Device User Guides*.<sup>77</sup>

The POS device can perform additional functions besides eligibility verification, some of which (such as claim submission) cannot be used for Drug Medi-Cal, though they are used in other Medi-Cal components.

A POS device may be requested by completing the following forms:

1. Medi-Cal Eligibility Verification Enrollment Form<sup>78</sup>
2. POS Device Usage Agreement<sup>79</sup>
3. Medi-Cal Point of Service Network/Internet Agreement<sup>80</sup>

Mail all three forms to:

POS Help Desk  
3215 Prospect Park Drive  
Rancho Cordova, CA 95670-6017

<sup>76</sup> Available online at <http://files.medi-cal.ca.gov/pubsdoco/userguides.asp> (accessed April 3, 2009).

<sup>77</sup> Cal. Dept. of Health Care Services, Medi-Cal, POS Device User Guides, [http://files.medi-cal.ca.gov/pubsdoco/pos\\_home.asp](http://files.medi-cal.ca.gov/pubsdoco/pos_home.asp) (accessed April 29, 2009).

<sup>78</sup> Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal Eligibility Verification Enrollment Form, [http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/part1/pointfrms\\_z01.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/part1/pointfrms_z01.doc) (accessed April 29, 2009).

<sup>79</sup> Cal. Dept. of Health Care Services, Medi-Cal, POS Device Usage Agreement, [http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/part1/pointfrm2dev\\_z01.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/part1/pointfrm2dev_z01.doc) (accessed April 29, 2009).

<sup>80</sup> Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal POS Network/Internet Agreement, [http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/pointfrm1net\\_z01.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/pointfrm1net_z01.doc) (accessed April 29, 2009).

### 3.3.3 Transaction Services on the DHCS Medi-Cal Website

Medi-Cal Transaction Services allow Medi-Cal providers to perform a variety of secure transactions over the internet, including eligibility verification. Additional information about the Medi-Cal Transaction Services system, including the required forms and usage information, is available in the *DHCS Medi-Cal Website Quick Start Guide*.<sup>81</sup> Note that Medi-Cal Transaction Services system can perform additional functions besides eligibility verification, some of which (notably, claim submission) cannot be used for Drug Medi-Cal, though they are used in other Medi-Cal components.

## 3.4 Technical Assistance for Medi-Cal Eligibility Verification Systems

If you have questions regarding the AEVS or the interpretation of AEVS and POS return codes and messages, contact the Telephone Service Center (TSC) at (800) 541-5555. For faster access to resources, refer to the *Main Menu Prompt Options Guide*<sup>82</sup> and the *TSC Specialized Operator Reference Guide*.<sup>83</sup>

If you need assistance using the POS device or have questions regarding the shipment of a POS device or other materials, contact the POS Help Desk at (800) 541-5555.

You may need to provide the operator your NPI, a PIN, and the fact that your NPI is certified by ADP in the SDMC system as an *Other Intermediary 02*. Help desk operators will provide a work request number as well as their names. Please retain this information until the issue is resolved.

If further assistance is needed, please send details to:

POS Help Desk  
3215 Prospect Park Drive  
Rancho Cordova, CA 95670-6017

<sup>81</sup> Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal Website Quick Start Guide, <http://www.medi-cal.ca.gov/pubs/quickstart.htm> (accessed April 29, 2009).

<sup>82</sup> Cal. Dept. of Health Care Services, Medi-Cal, Telephone Service Center, [http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/provrefrm1ref\\_z01.pdf](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/provrefrm1ref_z01.pdf) (accessed April 29, 2009).

<sup>83</sup> Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal Specialized Operator Reference Guide, [http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/provrefrm2\\_z01.pdf](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/provrefrm2_z01.pdf) (accessed April 29, 2009).



## **4. DRUG MEDI-CAL CLAIMS PROCESSING OVERVIEW**

## 4 Introduction

This chapter provides an overview to claims processing and includes:

- [Bridge Resubmissions](#)
- [Disallowance of Phase 1 Claims](#)
- [Claim Submission Requirements](#)
- [Transaction Sets used in DMC Billing](#)
- [Claims Processing Overview](#)

### 4.1 Bridge Resubmissions

ADP trading partners may resubmit claims for services that were denied in the Phase 1 system in the Phase 2 system. Because the Phase 2 system will not support replacement of Phase 1 claims, these resubmissions of Phase 1 claims in the Phase 2 system (known as *bridge resubmissions*) will be identified on the 837 as original claims in Phase 2. For each bridge resubmission submitted to ADP, a Bridge Resubmission for Phase 1 Claims Form must be completed by the trading partners and submitted to ADP. The form can be found on the “Drug Medi-Cal Billing” page of the ADP website.<sup>84</sup>

To assure traceability and proper processing, procedures similar to those used for resubmissions in Phase 1 will be applied to bridge resubmissions:

- Bridge resubmissions must be submitted in a separate Electronic Data Interchange (EDI) file from any other claims. Each bridge resubmission EDI file must contain resubmissions of claims denied in one Phase 1 claim batch; a separate EDI file is required for each batch resubmitted.
- Bridge resubmissions must be submitted via ITWS within six months of the date of the Phase 1 denial.<sup>85</sup> ADP will discontinue support for the bridge resubmission process six months after the last Phase 1 claim denials.
- Bridge resubmission forms must include the ITWS file name and batch number from the Phase 1 batch in which the claims were denied.

### 4.2 Disallowance of Phase 1 Claims

Because the Phase 2 system does not support voids to Phase 1 claims, ADP trading partners will continue to use the ADP 5035C to report any identified adjustments for any claims approved in the Phase 1 system, even after the Phase 2 cutover. Additional information about the use of the ADP 5035C for adjustment of Phase 1 claims is provided in Chapter 6 of this manual.

<sup>84</sup> DMC Billing [http://www.adp.ca.gov/dmc/dmc\\_billing.shtml](http://www.adp.ca.gov/dmc/dmc_billing.shtml)

<sup>85</sup> 22 Cal. Code Regs §51008(d)

### 4.3 Claim Submission Requirements

#### 4.3.1 Claim Submission Timelines

##### 4.3.1.1 Claim Submission Timeline—Original Claims

An original claim must be received by ADP not later than **30 days** after the end of the month in which the service was provided unless the provider has good cause for late claim submission.<sup>86</sup>

If a claim is submitted later than 30 days after the end of the month in which service was provided the provider must have good cause for the late submission. If the reason meets the criteria for Delay Reason Codes 4, 8, or 11, the county or direct contract provider must prepare a Good Cause Certification form and must include the appropriate delay reason code in the claim.<sup>87</sup> For Delay Reason Codes 4 and 11, pre-approval by ADP is required prior to submitting form ADP 6065A. For Delay Reason Code 8, which pre-approval is not required, form ADP 6065B must be submitted. Delay Reason Codes are used to document the reason that a DMC claim was submitted beyond the deadline of 30 days after the end of the month the service was provided (see Chapter 6 of this manual for details on their use.)

Technical information on the use of Delay Reason Codes in claims is included in the *Companion Guide: ADP – 837P*.<sup>88</sup>

##### 4.3.1.2 Claim Submission Timeline—Replacement Claims

A Replacement claim must be submitted not later than six months after the date the replaced claim was finalized (approved and paid, approved and payment deferred, or denied, as reported on an 835). Extensions will not be granted.

#### 4.3.2 Claim Certification Requirements

All claims submitted to ADP must be supported by a signed certification by the provider. The detailed requirements for the certification vary by the type of provider the services.

##### 4.3.2.1 Claim Certification for Direct Contract Providers

Direct contract providers are required to fax or mail a copy of a signed DMC Claim Submission Certification form (ADP 100185) to the Fiscal Management and Accountability branch (FMAB). A separate DMC Claim Submission Certification form must be submitted for each EDI file. Claims cannot be paid until ADP has a properly completed DMC Claim Submission Certification form on file.

<sup>86</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 6, §51490.1 (current through March 6, 2009)

<sup>87</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5 (current through March 6, 2009).

<sup>88</sup> Cal. Dept. of Health Care Services, *Companion Guide: ADP –837P* (2009).

#### *4.3.2.2 Claim Certification for County Contracted Providers*

County contract providers are required to submit a signed DMC Claim Submission Certification form (ADP 100186) for each DMC submission provided to the county for processing. The county must have, and complete the County Use portion of, a completed DMC Claim Submission Certification form certifying the claims for each county contracted provider prior to submitting a EDI file to ADP for adjudication. The forms shall be retained by the county and made available to ADP on demand.

#### *4.3.2.3 Claim Certification for County Operated Providers*

For each EDI file submitted that contains claim file information for county operated providers, the county is required to complete a DMC Claim Submission certification form (ADP 100187) certifying all claims within the file submitted for county operate providers. This form must be completed prior to submitting the EDI file to ADP. The form shall be retained by the county and made available to ADP on demand.

### **4.4 Transaction Sets Used in DMC Billing**

The HIPAA-mandated transaction standards used by ADP in DMC billing are identified in Section 1.3.3.2 of this manual, "Health Care Transactions and Code Sets". The transaction sets which ADP uses are:

- *837—Health Care Claim: Professional (837P)*: This standard transaction set is used by DMC trading partners to submit DMC claims.
- *835—Health Care Claim Payment/Advice (835)*: This standard transaction set is used by ADP to provide trading partners information on the payment or denial of DMC claims.
- *276—Health Care Claim Status Request (276)*: This standard transaction set is used by trading partners to request the status of claims which were previously submitted by the trading partner.
- *277—Health Care Claim Status Response (277)*: This standard transaction set is sent by to trading partners to provide status in response to a submitted 276 transaction set.
- *Unsolicited Claim Status (277U)*: While this is not a function for which a standard is specified in the HIPAA TCS rules, trading partners will receive a 277U transaction set to provide information on certain claim actions without first sending a 276 requesting status. 277U transaction sets will be sent immediately when claims are identified as either:
  - Awaiting manual override or delay reason certification, or
  - Adjudicated and approve by SDMC and awaiting payment processing by ADP.
- *997—Functional Acknowledgement (997)*: This transaction set (detailed in each of the standard implementation specifications, but not itself a standard transaction set) is returned as either an acknowledgement of acceptance or an

error report for each Functional Group of transaction sets submitted to ADP by trading partners.

All transactions submitted by or returned to trading partners are transferred via the Information Technology Web Services (ITWS) system, as described in Section 2.4 of this manual.

#### 4.4.1 Health Care Claims Transactions

There are three types of claims that may be submitted to ADP using the 837P transaction set:

- *Original claims* are claims submitted for the first time (never adjudicated). If a negative 997 is received in response to the HIPAA validation process, submitter may submit a new claim correcting the errors detailed in the 997.
- *Replacement claims* are requests to treat a previously finalized claim as null and void, and to adjudicate a corrected claim in place of the prior claim, retaining the original submission date of the replaced claim.
- *Void claims* are requests to treat a previously finalized claim as null and void.

Additional information on Void and Replacement claims follows.

##### 4.4.1.1 Void Claims

Trading partners should submit a Void claim when they have identified that a claim that was previously finalized should not have been billed to DMC. Once a claim has been voided, it cannot be voided again, nor can it be replaced.

If some claim information is inaccurate, but the claim should still have been billed, do not void the claim but instead submit a Replacement Claim (see next section). Guidelines on voiding claims and void scenarios are provided in the *ADP Companion Guide Appendix*.<sup>89</sup>

##### 4.4.1.2 Replacement Claims

A Replacement Claim allows trading partners to replace a previously finalized 837P claim.

Trading partners should replace claims when they have identified that either:

- The previously-submitted claim was submitted with incorrect information, or
- Service lines were erroneously included in or omitted from the claim.

Guidelines on Replacement Claims and replacement scenarios are provided in the *ADP Companion Guide Appendix*.

<sup>89</sup> Available on ADP's *HIPAA Privacy and Security* webpage at <http://www.adp.ca.gov/hp/hipaa.shtml>.

## **4.5 Claims Processing Overview**

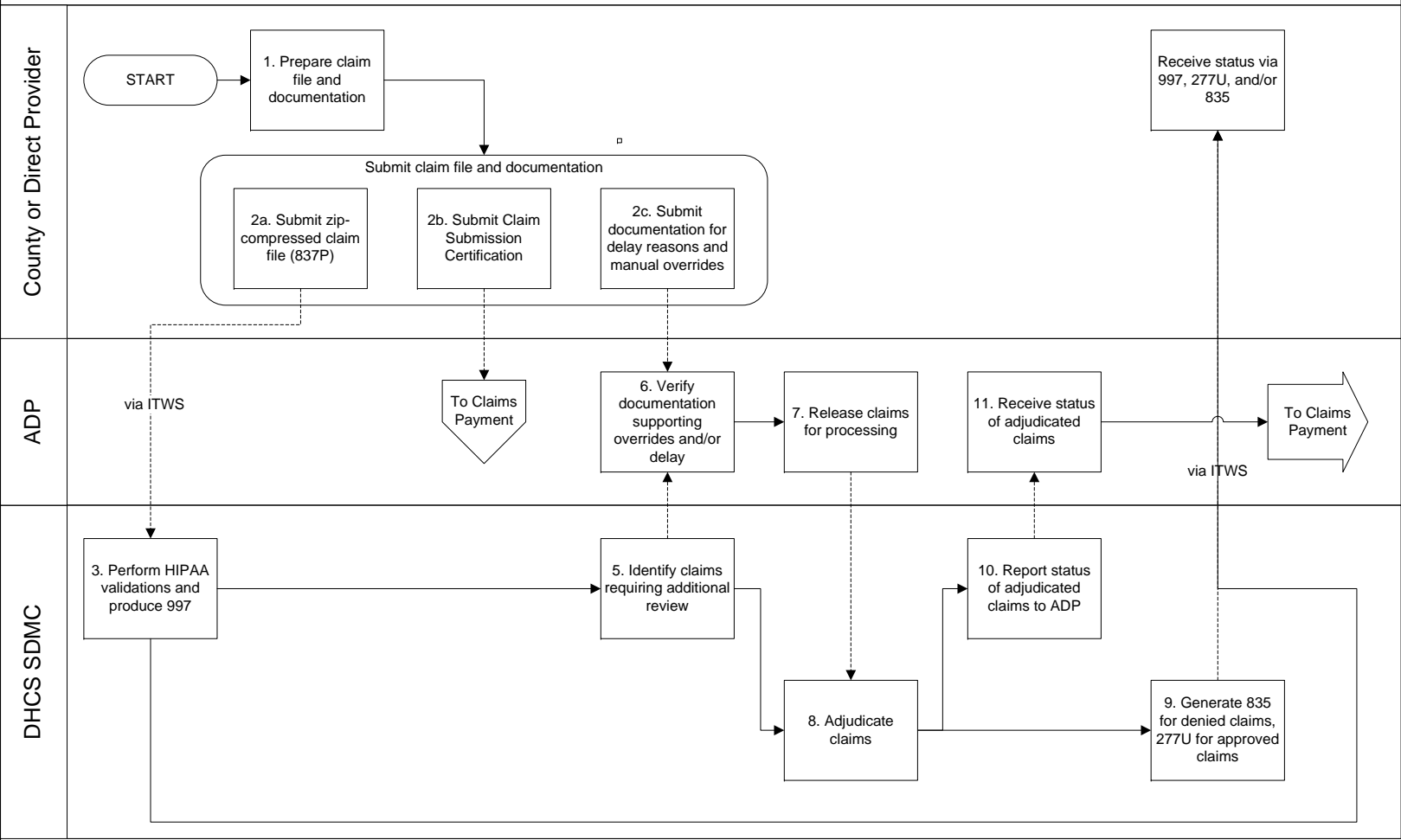
### **4.5.1 DMC Claims Submission and Adjudication**

1. Trading partner prepares claim file and supporting documentation.
  - a. Trading partner prepares file containing 837P transaction sets with DMC claims.
  - b. Responsible trading partner officials must complete DMC Claims Submission Certification Form described in Chapter 4 of this manual at Section 4.2.1.
  - c. If any claims submitted in the file include delay reason codes, one or more Good Cause Certification forms (ADP 6065A or 6065B) forms are prepared to support the use of the delay reason codes.
  - d. If any claims submitted in the file include requests for manual eligibility override, supporting documentation for those manual overrides is assembled and prepared.
2. Trading partner submits claim file and supporting documentation to ADP.
  - a. Trading partner submits file containing 837P transaction sets via ITWS.
  - b. Direct contract providers submit DMC Claim Submission Certification form to ADP via fax or mail.
  - c. If any claims submitted in the file include the use of delay reason codes requiring state approval (reason codes 4, 8, and 11), submission of ADP 6065A or 6065B must be submitted to the State. For delay reason codes 4 or 11, pre-approval from ADP is required prior to submitting the ADP 6065A. Trading partner submits documentation supporting the use of those delay reason codes to ADP via fax or email. Additional information on Good Cause Certification for use of delay reason codes is found in Section 6.7 of this manual.
  - d. If any claims submitted in the file include requests for manual eligibility overrides, trading partner submits documentation supporting eligibility of the clients for whom manual overrides are requested to ADP via fax or email.
3. When SDMC receives the file from ITWS, the SDMC system validates that the file received is a validly-formatted file. The SDMC system will produce and post a file containing a 997 transaction for every functional group identified in the submitted file, acknowledging the receipt of the functional group and identifying any syntactic errors identified in it.
4. If the file has been successfully validated, SDMC will process the claims in the file to identify any claims requiring additional certification prior to adjudication.
  - a. Any claims using delay reason codes requiring state approval will be held for review of the documentation supporting those delay reason codes, and will be reported on a 277U transaction set.
  - b. Any claims requesting manual eligibility overrides will be held for review of the documentation supporting eligibility, and will be reported on a 277U transaction set.

5. ADP will await receipt of the appropriate certification documents for any claims requiring certification of the use of delay reason codes and/or manual eligibility overrides.
6. Claims requiring certification of the use of delay reason codes or manual eligibility overrides will be released by ADP when the corresponding certification has been reviewed and approved. If the certification of the use of a delay reason code or manual override is not approved by ADP, the claim will be adjudicated as if the delay reason code or manual override was not provided.
7. Claims that do not require delay reason certification or manual eligibility override, or which do require either or both of those and have had the required certification reviewed by ADP, will be adjudicated by the SDMC system.
8. After adjudication, any claims which do not require payment or recovery processing by ADP (denied original claims, and void and replacement claims for which no prior claim was located) will be reported on 835 transaction sets made available to trading partners via ITWS, while those claims that require payment or recovery processing prior to finalization will have their status reported on 277U transaction sets.
9. After adjudication, all claim information is reported to ADP by SDMC.
10. When ADP receives claim information from SDMC, the claim information will be stored in ADP's databases, and any claims requiring payment or recovery processing will be identified.

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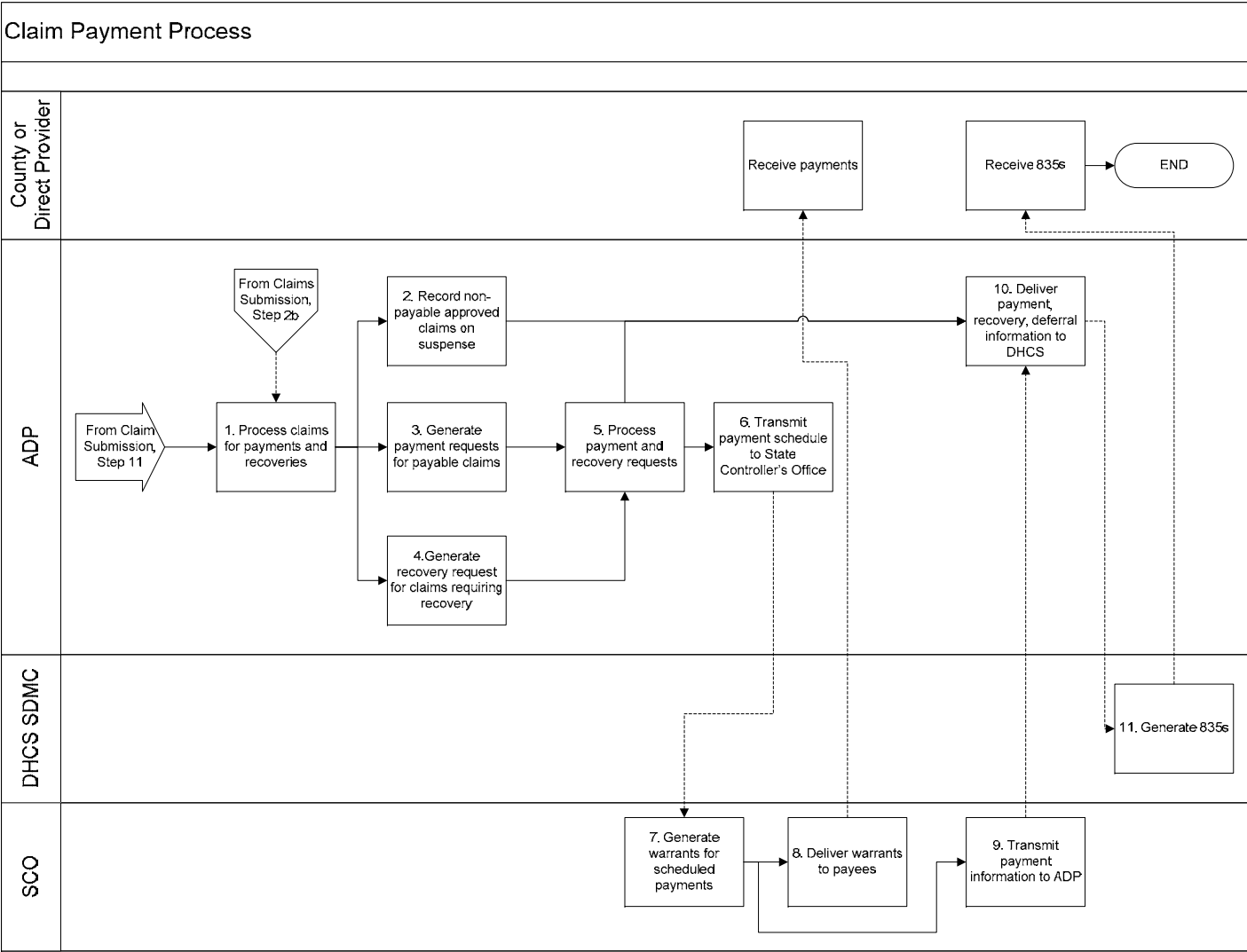
**Claim Submission and Adjudication Process**



**FIGURE 1: CLAIM SUBMISSION AND ADJUDICATION PROCESS**



<b>DRUG MEDI-CAL BILLING MANUAL</b>
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**FIGURE 2: CLAIM PAYMENT PROCESS**

#### 4.5.2 ADP Claim Payment and Recovery Processing

1. In each weekly claim processing cycle, ADP reviews all claims requiring payment or recovery that has not yet been taken. Claims from a direct contract provider where the corresponding certification has not been received will be deferred and processed once the certification has been received.
2. For each claim requiring a payment that cannot be made in full because of an insufficient contract balance, a payment hold, or other reason, the unpayable amount is identified as deferred; if no payment amount has been identified for this claim, the deferral of the entire payment will be transmitted to SDMC to be reported on an 835 if it has not already been. If a payment has been identified for this claim, the deferred amount will be reported along with the payment amount once the payment has been issued.
3. For each claim requiring a payment which can be made in part or in full, a payment request is generated for ADP's Accounting unit.
4. For each claim requiring a recovery, a recovery request is generated for ADP's Accounting unit.
5. ADP's Accounting unit will prepare payment schedules for all payment requests, offsetting against any outstanding recovery requests for the same trading partner; if the recoveries for a trading partner fully offset payments, the claims and adjustments involved will be transferred to SDMC to generate an 835, otherwise, the payments and adjustments will be listed together on an 835 once payment is issued.
6. ADP will transmit payment schedules to the State Controller's Office (SCO).
7. SCO will generate warrants for each trading partner according to the schedule submitted by ADP.
8. SCO will deliver payment warrants to trading partners.
9. SCO will transmit warrant information to ADP.
10. ADP will combine the warrant information with payment, recovery, and deferral information generated earlier in the process and transfer to SDMC.
11. SDMC will generate 835s detailing payments, recoveries, and deferred payments to trading partners via ITWS.

## **5. MULTIPLE SERVICE BILLINGS AND MONTHLY SERVICE LIMITS**

## 5 Introduction

This chapter provides an overview to DMC multiple service billings, lockouts and overrides and includes:

- [Multiple Service Billings](#)
- [Maximum Service Units and Lockouts](#)

### 5.1 Multiple Service Billings

*Multiple service billings* are claims for a second unit of service by the same DMC provider, on the same day, and for the same recipient that may be approved for reimbursement. Generally only one unit of service (except for Narcotic Treatment Program counseling, which is subject to a limit of 20 units of service per month, with no additional per-day limit) may be provided to a Medi-Cal-eligible recipient per treatment date. However, multiple service billings are permissible in specific exceptional circumstances.<sup>90</sup>

A multiple service billing claim must include the appropriate HIPAA procedure modifier as described in the *ADP Companion Guide Appendix*.<sup>91</sup>

When a multiple service billing is submitted, the provider must prepare and retain in the beneficiary's patient record, a Multiple Billing Override Certification (ADP 7700) documenting the circumstances justifying the multiple service billing.

#### 5.1.1 Restrictions

Multiple service billings are allowed for a return visit for a single additional service in a day for outpatient drug free (ODF), Naltrexone, and day care rehabilitative services.<sup>92</sup>

For outpatient drug free and Naltrexone treatment services:

- The return visit shall not create a hardship on the beneficiary; and
  - The return visit shall be clearly documented in the beneficiary's progress notes with the time of day each visit was made. The progress note shall clearly reflect that an effort was made to provide all necessary services during the one visit and the return visit was unavoidable; or,
  - The return visit shall be a crisis or collateral service. Collateral services shall be documented in the beneficiary's treatment plan in accordance with the beneficiary's short/long-term goals. The beneficiary's progress notes shall specifically reflect the steps taken to meet the goals defined in the beneficiary's treatment plan.

For day care rehabilitative services, the return visit shall be a crisis service. Crisis service shall be documented in the progress notes.

<sup>90</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 6, §51490.1(d) (current through March 6, 2009).

<sup>91</sup> Available on ADP's *HIPAA Privacy and Security* webpage at <http://www.adp.ca.gov/hp/hipaa.shtml>.

<sup>92</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 6, §51490.1(d) (current through March 6, 2009).

The county and/or provider shall prepare and keep on file a statement which documents the reason the beneficiary required a return visit. This statement shall be produced upon the request by ADP for audit or monitoring purposes.

Multiple service billings are not permitted for:

- Any DMC service other than ODF, Naltrexone, or day care rehabilitative services;
- Services provided by different providers on the same day; and
- Services provided from different DMC service types in the same day.

## 5.2 Maximum Service Units and Lockouts

Table 5-1 summarizes allowable multiple service billing combinations, monthly NTP counseling service limits, and excluded same-day DMC services.

**TABLE 5-1: ALLOWABLE AND EXCLUDED SAME-DAY SERVICES**

For Same Beneficiary on Same Date of Service									
Service Name	NTP Methadone Dosing	NTP LAAM Dosing	NTP Individual Counseling	NTP Group Counseling	DCR	RES	NAL	ODF Individual Counseling	ODF Group Counseling
Narcotic Treatment Program (NTP) Methadone Dosing	NO	NO	NTP	NTP	NO	NO	NO	NO	NO
NTP Levoalphacetylmethadol (LAAM) Dosing	NO	NO	NTP	NTP	NO	NO	NO	NO	NO
NTP Individual Counseling	NTP	NTP	NTP	NTP	NO	NO	NO	NO	NO
NTP Group Counseling	NTP	NTP	NTP	NTP	NO	NO	NO	NO	NO
Day Care Rehabilitative (DCR)	NO	NO	NO	NO	YES	NO	NO	NO	NO
Perinatal Residential (RES)	NO	NO	NO	NO	NO	NO	NO	NO	NO
Naltrexone (NAL)	NO	NO	NO	NO	NO	NO	YES	NO	NO
Outpatient Drug Free (ODF) Individual Counseling	NO	NO	NO	NO	NO	NO	NO	YES	YES
Outpatient Drug Free (ODF) Group Counseling	NO	NO	NO	NO	NO	NO	NO	YES	NO

NO	These services are not permitted to be reimbursed for the same client on the same day.
NTP	These services are permitted to be reimbursed for the same client on the same day, subject to a limit of a total of 200 minutes (20 units) of NTP counseling per client per month.
YES	These services are permitted to be reimbursed on the same day for the same client, subject to multiple billing restrictions. The appropriate multiple service billing procedure modifier must be identified for the return visit.

## **6. FORMS**

## 6 Introduction

This chapter provides an overview of ADP claim forms, which can be found on the “Drug Medi-Cal Billing” page of the ADP website.<sup>93</sup>

- [DMC Claim Submission Certification – Direct Contract Provider Form \(ADP 10085\)](#)
- [DMC Claim Submission Certification – County Contracted Provider Form \(ADP 10086\)](#)
- [DMC Claim Submission Certification – County Operated Provider\(s\) Form \(ADP 10087\)](#)
- [Provider Report of Drug Medi-Cal Adjustments \(ADP 5035C\)](#)
- [Multiple Billing Override Certification \(ADP 7700\)](#)
- [Bridge Resubmission](#)
- [Good Cause Certification \(ADP 6065A\)](#)
- [Good Cause Certification \(ADP 6065B\)](#)

### 6.1 DMC Claim Submission Certification Direct Contract Provider Form (ADP 10085)

Direct contract providers are required to submit a signed DMC Claim Submission Certification – Direct Contract Provider Form to ADP by mail or fax for each EDI claim file submitted to ADP. Payments for adjudicated claims will not be released until this form is received and approved by ADP

### 6.2 DMC Claim Submission Certification – County Contracted Provider Form (ADP 10086)

County contracted providers are required to submit a signed DMC Claim Submission Certification – County Contracted Provider Form for each DMC submission provided to the county for processing.

### 6.3 DMC Claim Submission Certification – County Operated Provider(s) Form (ADP 10087)

The County is required to complete a DMC Claim Submission Certification – County Operated Provider(s) Form for each EDI file submitted for county operated providers. Only one form has to be completed per EDI file certifying all claims within the file submitted for county operated providers.

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<sup>93</sup> Cal. Dept. of Alcohol and Drug Programs, “Drug Medi-Cal Billing,” [http://www.adp.ca.gov/dmc/dmc\\_billing.shtml](http://www.adp.ca.gov/dmc/dmc_billing.shtml) (accessed January 22, 2010)

#### **6.4 Provider Report of Drug Medi-Cal Adjustments (ADP 5035C)**

Because the SDMC Phase 2 system will not support voids to Phase 1 claims, ADP trading partners must continue to use the ADP 5035C to report any identified adjustments for claims approved and paid in the Phase 1 system, even after the Phase 2 cutover.

#### **6.5 Multiple Billing Override Certification (ADP 7700)**

ADP 7700 is used to certify that an additional, second unit of service for the same client was submitted for the same service date. ADP 7700 documents that the additional service was medically necessary and was not a hardship for the client's return.

The ADP 7700 must be signed by a person authorized to represent the provider to certify that the client record was reviewed, that the multiple service claim was valid per Section 51490.1 of Title 22,<sup>94</sup> and that the ADP 7700 shall be prepared and retained in the beneficiary's patient record to be produced for monitoring and/or auditing purposes.

#### **6.6 Bridge Resubmission**

The Bridge Resubmission form is used to identify denied claims from the Short-Doyle/Medi-Cal (SDMC) Phase 1 system that are being submitted in the SDMC Phase 2 system. Such claims must be submitted within six months of the date of the Phase 1 denial, as shown in the Phase 1 835.

#### **6.7 Good Cause Certifications (ADP 6065A and 6065B)**

The ADP 6065A and 6065B forms are used by the provider and/or county to document and support the reason a claim is being submitted outside of the required due date. A late claim is any claim submitted later than 30 days after the last date of the service year and month; i.e., a timely claim for July 2010 should be submitted to ADP no later than August 30, 2010. The Good Cause, (Delay Reason code in the 837P) must be coded on any late claim to avoid being denied due to late submission.

Delay Reason Codes are required to justify all late submission. The reasons for justifying late submission are defined in CCR Title 22, Section 51008.5.<sup>95</sup> If the late claim is submitted within the time limitation defined for the Good Cause, in Title 22, a Delay Reason code may be coded in the 837P claim submitted to ADP. Again, reference Title 22, Section 51008.5 for complete information on the regulation.

The ADP 6065A or 6065B should be completed and signed by a person authorized to represent the county/direct provider certifying the validity of the billing. With exception of the Delay Reason code 4, 8 or 11, do not submit the forms to ADP. The completed ADP forms 6065A or 6065B must be retained on site for monitoring purposes.

<sup>94</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 6, §51490.1 (current through March 6, 2009).

<sup>95</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5 (current through March 6, 2009).



Use of Delay Reason code 4 or 11 must be pre-approved by ADP. Once ADP has issued pre-approval, ADP 6065A must be prepared and submitted to ADP for signature and final approval. After approval is granted, the claims will be released from the system and the signed ADP 6065A will be faxed back to county/direct provider by ADP and retained on site for monitoring purposes.

While use of Delay Reason code 8 does not require pre-approval by ADP, ADP 6065B must be prepared and submitted to ADP for signature and final approval. After approval is granted, the claims will be released from the system and the signed ADP 6065B will be faxed back to county/direct provider by ADP and retained on site for monitoring purposes.

#### 6.7.1 *Good Cause for Late Submission and Delay Reason Codes*

The county/direct provider must determine the appropriate Delay Reason code to use on the ADP 6065A. ADP cannot advise which Delay Reason code to use.

The Delay Reason code should be included in the late claim at the time of submission. If it is overlooked and the claim is denied, the Delay Reason Cause code may be used in the replacement claim.

Providers must meet one of the seven situations below in order to qualify for delay reason cause exemption. For a late submission situation to be applicable for a Delay Reason, it must adhere to all time limits and documentation requirements. Most Delay Reason codes have a time limitation of one year from the date of service to submit the claim. ADP has included a brief description of Delay Reason codes, but it is suggested that CCR Title 22, Section 51008.5 be reviewed for complete information and instructions.<sup>96</sup>

#### *Delay Reason Code 1<sup>97</sup>*

Delay is due to a failure of the client or legal representative, due to deliberate concealment or physical or mental incapacity, to present identification as a Medi-Cal beneficiary.

- Provider or county must identify the client as having been Medi-Cal eligible on the date of service within one year following the end of the month in which the service was rendered.
- Claims must be submitted to and received by ADP not later than 60 days from the date the client was first identified as a Medi-Cal beneficiary.
- Provider and/or county must maintain documentation of the date of service and date the client was identified as a Medi-Cal beneficiary.
- Provider and/or county's documentation of date of service may include:
  - Medi-Cal ID card, Medi label or Proof of Eligibility (POE) label.

<sup>96</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5 (current through March 6, 2009).

<sup>97</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(1) (current through March 6, 2009).

- Any of the above indicating Kaiser, Ross-Loos or CHAMPUS coverage, when accompanied by denial of coverage by that carrier.
- Photocopy of the Medi-Cal Beneficiary Card or Medi/POE labels.

*Delay Reason Code 2*<sup>98</sup>

Delay is due to the initiation of legal proceedings to obtain payment from a liable third party pursuant to Section 14115 of the Welfare and Institutions Code.

- Claims must be submitted to and received by ADP not later than one year after the end of the month in which services were rendered.

*Delay Reason Code 4*

Determination by the Director of DHCS, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control, where the circumstance is either delay in the certification or recertification of the provider to participate in the DMC program by the State or delay by DHCS in enrolling a provider.<sup>99</sup>

- Claims must be submitted to and received by ADP not later than one year after the end of the month in which services were rendered.
- Documentation of justification for request of Good Cause must be forwarded to ADP by the county/direct contract provider, and must include:
  - Date of services and insurance claim reports, newspaper clippings, photographs of damages, etc.
- Documentation must be maintained by county and/or provider on site.

*Delay Reason Code 7*<sup>100</sup>

Billing involving other coverage, including but not limited to Medicare, Kaiser, Ross-Loos, or CHAMPUS.

- Claims must be submitted to and received by ADP not later than the earliest of one year after the end of the month in which services were rendered and 60 days from the date of notification that third party payment was denied.
- Provider and/or county must maintain documentation of the date of service and the notification of the denial of payment by the third party.

*Delay Reason Code 8*<sup>101</sup>

Determination by the Director of DHCS, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the

<sup>98</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(3) (current through March 6, 2009).

<sup>99</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(4)(E) (current through March 6, 2009).

<sup>100</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(2) (current through March 6, 2009).

<sup>101</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(4)(A) (current through March 6, 2009).

provider's control, specifically due to a delay or error in the client/beneficiary's Medi-Cal eligibility being determined or certified by the state or county. This also applies to retroactive Medi-Cal eligibility.

- Claims must be submitted to and received by ADP not later than one year after the end of the month in which services were rendered.
- Provider and/or county must maintain documentation of the date of service and a copy of application of Medi-Cal benefits (e.g., Supplemental Security Income [SSI] or State Supplementary Payment [SSP]) and copy of client retroactive eligibility determination.

*Delay Reason Code 10 (time limit: 60 days from resolution of circumstances causing delay)<sup>102</sup>*

Special circumstances that cause a billing delay such as a court decision or fair hearing decision.

- Claims must be submitted to and received by ADP not later than 60 days from the resolution of the circumstances justifying the delay.
- Provider and/or county must maintain documentation on file which includes:
  - Justification, cause and reason of delay.
  - Resolution of the delay, including the date of resolution.

*Delay Reason Code 11*

Determination by the Director of DHCS, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control, specifically due to:

- Damage to or destruction of the provider's business office or records by a natural disaster; includes fire, flood or earthquake,<sup>103</sup> or
- Circumstances resulting from such a disaster have substantially interfered with processing bills in a timely manner;
- Theft, sabotage or other deliberate, willful acts by an employee;
- Other circumstances which may be clearly beyond the provider and/or county's control and have been reported to the appropriate law enforcement or fire agency when applicable.

<sup>102</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(b)(5) (current through March 6, 2009).

<sup>103</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(4)(B) (current through March 6, 2009).

Circumstances that *will not be considered* beyond the control of the provider include, but are not limited to:<sup>104</sup>

- Negligence by employees
- Misunderstanding of or unfamiliarity with Medi-Cal regulations.
- Illness or absence of any employee trained to prepare bills.
- Delays caused by U.S. Postal Service or any private delivery service.

Claims must be submitted to and received by ADP not later than one year after the end of the month in which services were rendered.

- Documentation of justification for request of Good Cause must be forwarded to ADP by the county/direct contract provider, and must include:
  - Date of services and insurance claim reports, newspaper clippings, photographs of damages, etc.
- Documentation must be maintained by county and/or provider on site.

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<sup>104</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(b)(1-4) (current through March 6, 2009).

**DRUG MEDI-CAL BILLING MANUAL**

**Appendix A: Glossary and Acronyms**

**APPENDIX A: GLOSSARY AND ACRONYMS**

<b>276</b>	The Claim Status Request transaction used to obtain claim status information after claim submission.
<b>277</b>	The Claim Status Response transaction generated in response to the 276 Status Request transaction.
<b>277U</b>	An Unsolicited Claim Status transaction sent by SDMC without the trading partner's request.
<b>837P</b>	Health Care Claim Transaction for Professional Claims/Encounters.
<b>835</b>	The Health Care Claim Payment/Advice transaction (also known as a Remittance Advice or RA).
<b>997</b>	SDMC generates a 997 acknowledgement in response to each HIPAA-compliant transaction.
<b>AB</b>	Assembly Bill
<b>Administrative Costs</b>	A contractor's actual direct costs, as recorded in the contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, program review, and activities related to billing. Administrative costs may include contractor's overhead per the approved indirect cost rate proposal pursuant to Federal Office of Management and Budget Circular A-87 or A-122. <sup>105</sup>
<b>ADP</b>	Department of Alcohol and Drug Programs
<b>AEVS</b>	Automated Eligibility Verification System
<b>ANSI</b>	American National Standards Institute
<b>AOD</b>	Alcohol and Other Drugs
<b>ASC</b>	Accredited Standards Committee
<b>ASPE</b>	United States Assistant Secretary for Planning and Evaluation
<b>Beneficiary</b>	A person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the <i>Diagnostic and Statistical Manual of Mental Disorders III Revised (DSM)</i> , and/or DSM IV criteria; and (d) meets the admission criteria to receive DMC covered services.

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<sup>105</sup> U.S. White House Office of Management and Budget, "Circular A-87," [http://www.whitehouse.gov/omb/circulars\\_a087\\_2004](http://www.whitehouse.gov/omb/circulars_a087_2004) (accessed April 29, 2009); U.S. White House Office of Management and Budget, "Circular A-122," [http://www.whitehouse.gov/omb/circulars\\_a122\\_2004](http://www.whitehouse.gov/omb/circulars_a122_2004) (accessed April 29, 2009).

**DRUG MEDI-CAL BILLING MANUAL****Appendix A: Glossary and Acronyms**

<b>BIC</b>	Benefits Identification Card
<b>CalWORKS</b>	California Work Opportunity and Responsibility to Kids
<b>CalOMS</b>	California Outcomes Measurement System. A statewide client-based data collection and outcomes measurement system.
<b>CCR</b>	California Code of Regulations
<b>CFR</b>	Code of Federal Regulations; also, County of Financial Responsibility
<b>CIN</b>	Client Index Number (first 9 digits of the BIC).
<b>Client</b>	Anyone who is receiving alcohol or drug services.
<b>Covered Services</b>	Those DMC services authorized by Title XIX of the Social Security Act; <sup>106</sup> Title 22 Section 51341.1; <sup>107</sup> Health and Safety Code Section 11758.46; <sup>108</sup> and California's Medicaid State Plan. Covered services are Naltrexone treatment, outpatient drug-free treatment, narcotic replacement therapy, day care rehabilitative (for pregnant, postpartum, and EPSDT beneficiaries only), and perinatal residential AOD treatment (excluding room and board).
<b>CMS</b>	Centers for Medicare and Medicaid Services (U.S. Department of Health and Human Services)
<b>Crosswalk</b>	Cross-reference table
<b>DCH</b>	Day Care Habilitative
<b>DCR</b>	Day Care Rehabilitative
<b>DHCS</b>	Department of Health Care Services (formerly DHS)
<b>DHS</b>	Department of Health Care Services
<b>DMC</b>	Drug Medi-Cal. The state program wherein beneficiaries receive covered services from DMC-certified AOD treatment providers that are reimbursed for those services with a combination of federal Medicaid funds and/or State General Funds (SGF).
<b>DMH</b>	Department of Mental Health
<b>DP</b>	Direct Provider. A DMC certified provider that contracts directly with ADP for DMC reimbursement. .
<b>DSS</b>	Department of Social Services
<b>EDI</b>	Electronic Data Interchange
<b>EPSDT</b>	Early and Periodic Screening, Diagnosis and Treatment. The federally mandated Medicaid benefit that entitles full-scope Medi-

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<sup>106</sup> 42 U.S.C. chap. 7, subchap. XIX, §1396-1396v (current through Jan. 3, 2007).

<sup>107</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1 (current through March 6, 2009).

<sup>108</sup> Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46 (2008).

**DRUG MEDI-CAL BILLING MANUAL****Appendix A: Glossary and Acronyms**

	Cal-covered beneficiaries under 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.
<b>EPSDT Supplemental Service</b>	The supplemental individual outpatient drug-free (ODF) counseling services provided to beneficiaries eligible for the EPSDT program. Supplemental individual ODF counseling consists of any necessary individual AOD counseling not otherwise included in the ODF counseling under DMC.
<b>EVC</b>	Eligibility Verification Confirmation number. AEVS accesses the most current recipient information for a specific month of Medi-Cal eligibility and returns a 10-character EVC number if eligibility is confirmed. The EVC number may be entered in the remarks area of the claim, but it is not required. EVC information includes the client's eligible Aid Code(s).
<b>FAQs</b>	Frequently Asked Questions
<b>Finalized Claim</b>	A claim that is approved and paid, approved and payment deferred, or denied, as reported on an 835.
<b>FFP</b>	Federal Financial Participation. The share of federal Medicaid funds for reimbursement of DMC services. The FFP sharing ratio is determined on an annual basis and known as the Federal Medical Assistance Percentages (FMAP). <sup>109</sup>
<b>FFS</b>	Fee for Service
<b>FMAB</b>	Fiscal Management and Accountability Branch
<b>FMAP</b>	Federal Medicaid Assistance Percentages
<b>FY</b>	Fiscal Year
<b>GF</b>	General Fund
<b>HCPCS</b>	Healthcare Common Procedure Coding System. A set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).
<b>HIPAA</b>	Health Insurance Portability and Accountability Act of 1996 <sup>110</sup>
<b>HP</b>	Hewlett Packard. The company currently contracted to provide Medi-Cal telephone support and other related services (formerly known as EDS – Electronic Data Systems)

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<sup>109</sup> U.S. Dept. of Health & Human Services, "Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures (FMAP)," <http://aspe.hhs.gov/health/fmap.htm> (current through April 29, 2009).

<sup>110</sup> Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104<sup>th</sup> Cong., 2<sup>nd</sup> sess., (Aug. 21, 1996).

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<b>IA</b>	Interagency Agreement
<b>ICD-9</b>	International Classification of Diseases, 9th Edition
<b>ITWS</b>	Information Technology Web Services
<b>LAAM</b>	Levoalphacetylmethadol (a narcotic replacement drug which is currently unavailable in the United States)
<b>LCD</b>	The Licensing and Certification Division of ADP
<b>Medi-Cal</b>	California's Medicaid program
<b>Medical Necessity</b>	AOD treatment services that are reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness, or injury or in the case of EPSDT, services that meet the criteria specified in Title 22. <sup>111</sup>
<b>MEDS</b>	The DHCS Medi-Cal Eligibility Data System
<b>Minor Consent DMC Services</b>	Those covered services that, pursuant to Family Code Section 6929, may be provided to persons 12-20 years old upon their request without requiring parental consent or court consent <sup>112</sup>
<b>NAL</b>	Naltrexone
<b>NCCA</b>	National Commission for Certifying Agencies
<b>NPI</b>	National Provider Identifier
<b>NTP</b>	Narcotic Treatment Program. An outpatient clinic licensed by the State to provide narcotic replacement therapy using methadone directed at stabilization and rehabilitation of persons who are opiate-addicted and have an AOD diagnosis.
<b>ODF</b>	Outpatient Drug Free
<b>Perinatal DMC Services</b>	Covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services. <sup>113</sup>
<b>PHI</b>	Patient Protected Health Information
<b>PIN</b>	Provider Identification Number
<b>POE</b>	Proof of Eligibility
<b>POS</b>	Point of Service

<sup>111</sup> 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51340.1 (current through March 6, 2009).

<sup>112</sup> Cal. Family Code, div. 11, part 4, chap. 3, §6929 (2008).

<sup>113</sup> 22 Cal. Code Regs., div 3, subdiv. 1, chap. 3, art. 4, §51341.1(c)4 (current through March 6, 2009).



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<b>Postpartum</b>	(As defined for DMC purposes) means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60th day occurs.
<b>PSPP</b>	Post Service Post Payment. The utilization review for program compliance and medical necessity conducted by the State after service was rendered and the claim paid. State may recover prior payments if such review determines that the services did not comply with the applicable statutes, regulations, or standards.
<b>Projected Units of Service</b>	The number of reimbursable DMC units of service the contractor expects to provide on an annual basis.
<b>Protected Population</b>	(1) EPSDT-eligible Medi-Cal beneficiaries under age 21, and (2) Medi-Cal-eligible pregnant and postpartum women.
<b>Provider</b>	A supplier of alcohol and drug treatment services in California.
<b>Provider of DMC Services</b>	Any person or entity that provides direct AOD treatment services and has been certified by State as meeting the standards for participation in the DMC program set forth in the DMC Certification Standards for Substance Abuse Clinics, Document 2E and Standards for Drug Treatment Programs (October 21, 1981), Document 2F.
<b>RA</b>	Remittance Advice. The 835 Health Care Claim Payment/Advice transaction.
<b>RES</b>	Residential (Perinatal)
<b>ROPCB</b>	The Residential and Outpatient Programs Compliance Branch in ADP
<b>SAEVS</b>	Supplemental Automated Eligibility Verification System
<b>Satellite Site</b>	The same meaning as defined in the Drug Medi-Cal Certification Standards for Substance Abuse Clinics document which can be found on the ADP "Support Files" page. <sup>114</sup>
<b>SB</b>	Senate Bill
<b>SCO</b>	State Controller's Office
<b>SCHIP</b>	State Children's Health Insurance Program
<b>SDMC</b>	The Short-Doyle/Medi-Cal Act of 1957.
<b>SDMC System</b>	Short-Doyle/Medi-Cal system. The claims processing system operated by the Department of Health Services to process SDMC claims.

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<sup>114</sup> Cal. Dept. of Alcohol and Drug Programs, "Support Files," [http://www.adp.state.ca.us/NNA/support\\_files.shtml](http://www.adp.state.ca.us/NNA/support_files.shtml) (accessed April 29, 2009).

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<b>SGF</b>	State General Funds
<b>SMA</b>	Statewide Maximum Allowances. The maximum amount authorized to be paid by DMC for each covered unit of service for outpatient drug free, day care rehabilitative, perinatal residential, and Naltrexone treatment services. Rates are subject to change annually.
<b>SOC</b>	Share of Cost
<b>SSA</b>	Social Security Administration
<b>SSI</b>	Supplemental Security Income
<b>SSN</b>	Social Security Number
<b>SSP</b>	State Supplementary Payment
<b>Subcontract</b>	An agreement between the Contractor and its Subcontractors. A Subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/client services.
<b>Subcontractor</b>	An individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a direct provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to provide any of the administrative functions related to fulfilling the Contractor's obligations.
<b>TAPS</b>	Tracking and Payment System. An ADP database which holds claim status information, for Phase 1 claims.
<b>Title IX</b>	Portion of California Code of Regulations covering alcohol and drug services
<b>Trading Partners</b>	Counties and direct providers that contract with ADP for DMC reimbursement.
<b>TSC</b>	Telephone Service Center
<b>UOS</b>	Unit of Service. A face-to-face contact on a calendar day for outpatient drug free, day care rehabilitative, perinatal residential, and Naltrexone treatment services. Only one face-to-face service contact per day is covered by DMC except in the case of emergencies when an additional face-to-face contact may be covered for intake crisis intervention or collateral service. To count as a unit of service, the second contact shall not duplicate the services provided on the first contact, and each contact shall be clearly documented in the beneficiary's record.
<b>USC</b>	United States Government Code

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**USDR**

Uniform Statewide Daily Reimbursement Rate. The rate for NTP services based on a unit of service that is a daily treatment service provided.

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Appendix B: ITWS Enrollment

#### **APPENDIX B: ITWS ENROLLMENT**

ADP's DMC trading partners must submit DMC claims through the ITWS secure portal at <https://mhhitws.cahwnet.gov/default.asp>.

Trading partners must submit an Approver Form to request authorization for assigning/approving users for access to their organization's area of ITWS. Information and approver forms can be found under the "Support" menu on ITWS at <https://mhhitws.cahwnet.gov/default.asp>

Trading partners must request that their authorized users enroll to obtain a username and password before logging onto ITWS to access the SDMC-ADP system. User must enter their assigned username/password to submit claims and access claim status information.

To obtain a username/password go to the following website and follow the instructions. <https://mhhitws.cahwnet.gov/default.asp>

### **APPENDIX C: ITWS CLAIM SUBMISSION INSTRUCTIONS**

Once ITWS enrollment is approved, DMC claims can be submitted via ITWS.

1. Open a browser and type the ITWS web address: <https://mhhitws.cahwnet.gov>
2. Enter the username/password requested during enrollment under "ITWS Login."
  - a. Logon can also be done using the "Login" button on the "Welcome" page.
  - b. Once logged on, the "Login" button in the top menu bar changes to "Logout." Use this button when leaving ITWS.
  - c. The first page after logging on will be the "Home" page. Later you can use the "Home" button in the top menu bar to return to this page (menu buttons display on all ITWS pages).
3. Select the "Systems" button followed by "Short-Doyle/Medi-Cal Claims" under "ADP-Alcohol and Drug Program."
4. The next page provides System Messages. Select "Transfer Files (Upload and Download)" from the "Functions" menu.
5. On the "Transfer Files" page select "SDMC-ADP Information" in the drop down menu labeled "Choose a System," if not already selected.
6. Under "UPLOAD," select the county or direct provider in the drop down menu. Select here to upload files for another county. The left side of the page lists any previously uploaded 837P files and the acknowledgement of 997 files.
7. To submit an 837P file, select the "Add..." button. Use the dialog box to select the 837P claim file to upload.
8. Once the file is located, select it and press "OK" in the dialog box.
9. The file displays in the "UPLOAD" section of the "Transfer Files" page. Click the "Upload" button below the file listing.
10. A message box displays to verify that a file is being uploaded. If the file is correct, click the "OK" button.
11. The "File Upload" page appears with the message on success of the upload and a link to the "Processing Status" page to view the tracking of the uploaded file.
12. To return to the "Transfer Files" page click the "Return to Transfer Page" button at bottom of dialog box.
13. The file that was just uploaded will be displayed on the left side.

14. E-mail acknowledgements from ITWS are generated with status messages.

**APPENDIX D: CHECKING ITWS “PROCESSING STATUS”**

1. The “Processing Status” page can be checked for the status of a submitted 837P claim. Log onto ITWS and select “Processing Status” from the “Functions” menu.
2. The “Processing Status” page displays. Select “SDMC-ADP” from the “Choose a system” drop down menu. The menu options in the “Show files within list box” can be used to limit the number of files submitted to be listed in the specified time.
3. The “Processing Status” page displays tracking messages posted for each 837P file.

### **APPENDIX E: DOWNLOADING THE 835 REMITTANCE ADVICE**

The SDMC adjudicated, approved and denied, 837P claim information will be reported in the HIPAA 835 transaction file. The 835 Healthcare Claim Remittance Advice (RA) is available for download from the ITWS “Transfer Files” page in the location where the submitted 837P and 997 acknowledgement files are posted.

The 835 RA can be used for reconciliation with 837P claim information and as a basis for Replacement or Void claims when necessary.

- Trading partners must be enrolled on ITWS to access the SDMC–ADP system to download 835 RA files.
- The 835 RA files should be downloaded, extracted, and retained in a safe and secure location to protect the contents of the file from inappropriate access.
- To download the 835 RA, go to the ITWS website at <https://mhitws.cahwnet.gov/default.asp> and logon with the appropriate ITWS username and password; use either the “Logon” menu button or the “Username” and “Password” entry boxes in the “ITWS Login” area.
- Under “Systems” menu select “ADP–Alcohol and Drug Program,” then “Short-Doyle/Medi-Cal Claims”
- Select “Transfer Files (Upload and Download)” on the option under the “Functions” menu button.
- The “Transfer Files” page lists any available electronic data interchange (EDI) HIPAA files.
- To download an 835 file, highlight and select.
- A “Download File” dialogue box will display; select the “Save” button. This will allow selection of a safe location for saving the file.
- The “Save As” (in the browser) should display allowing you to search for a folder or create a new folder in a secure area of the organization’s system.
- The compressed file can be opened using the county or direct provider’s password, and can be imported into the trading partner’s database, application or system in a text reader file.
- The format for the password can be viewed at the bottom of the ITWS “System Messages” page (a user ID and password are required to view the page).



**APPENDIX F: LINKS TO FREQUENTLY ASKED QUESTIONS**

**Narcotic Treatment Program (NTP)**

<http://www.adp.ca.gov/ADPLTRS/pdf/97-46ex1.pdf><sup>115</sup>

**HIPAA Compliance**

<http://www.adp.ca.gov/hp/hipaa.shtml><sup>116</sup>

**Licensing**

<http://www.adp.ca.gov/Licensing/faqs.shtml><sup>117</sup>

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<sup>115</sup> Cal. Dept. of Alcohol and Drug Programs, "Narcotic Treatment Program (NTP) Specific Questions," <http://www.adp.ca.gov/ADPLTRS/pdf/97-46ex1.pdf> (accessed April 29, 2009).

<sup>116</sup> Cal. Dept. of Alcohol and Drug Programs, "HIPAA Privacy & Security," <http://www.adp.ca.gov/hp/hipaa.shtml> (accessed April 29, 2009).

<sup>117</sup> Cal. Dept. of Alcohol and Drug Programs, Licensing, "Frequently Asked Questions," <http://www.adp.ca.gov/Licensing/faqs.shtml> (accessed April 29, 2009).

**APPENDIX G: HYPERLINKS TO MATERIALS REFERENCED IN THIS MANUAL**

- Cal. Dept. of Alcohol and Drug Programs, "Bulletin 07-04,"  
[http://www.adp.ca.gov/ADPLTRS/PDF/ADP\\_Bulletin\\_07-04.pdf](http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_07-04.pdf) (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Bulletin 08-01,"  
[http://www.adp.ca.gov/ADPLTRS/PDF/ADP\\_Bulletin\\_08-01.pdf](http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_08-01.pdf) (accessed April 29, 2009).
- Cal. Alcohol and Drug Programs, "Bulletin 08-12,"  
[http://www.adp.ca.gov/ADPLTRS/PDF/ADP\\_Bulletin\\_08-12.pdf](http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_08-12.pdf) (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Bulletin 98-44,"  
[http://www.adp.ca.gov/ADPLTRS/PDF/ADP\\_Bulletin\\_98-44.pdf](http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_98-44.pdf). (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Bulletin 99-07,"  
[http://www.adp.state.ca.us/ADPLTRS/PDF/ADP\\_Bulletin\\_99-07.pdf](http://www.adp.state.ca.us/ADPLTRS/PDF/ADP_Bulletin_99-07.pdf) (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Bulletin 99-39,"  
[http://www.adp.ca.gov/ADPLTRS/PDF/ADP\\_Bulletin\\_99-39.pdf](http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_99-39.pdf) (accessed April 29, 2009).
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[http://www.adp.ca.gov/ADPLTRS/bulletin\\_letter.shtml](http://www.adp.ca.gov/ADPLTRS/bulletin_letter.shtml) (accessed April 29, 2009).
- Cal. Alcohol and Drug Programs, "Calendar of Events,"  
<http://www.adp.ca.gov/calendar.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "CalOMS Prevention,"  
<http://www.adp.ca.gov/CalOMS/CalOMSPrevention.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "CalOMS Treatment,"  
<http://www.adp.ca.gov/CalOMS/CalOMSmmain.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Confidentiality Statement for Drug Medi-Cal Patient Data," <http://www.adp.ca.gov/dmc/pdf/confidentiality.pdf> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Contact ADP,"  
<http://www.adp.ca.gov/contact.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Document Library,"  
<http://www.adp.ca.gov/Library/index.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "DMC EPSDT Fact Sheet,"  
[http://www.adp.ca.gov/FactSheets/EPSDT\\_Fact\\_Sheet\\_v4.pdf](http://www.adp.ca.gov/FactSheets/EPSDT_Fact_Sheet_v4.pdf) (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "DMC Minor Consent Services Fact Sheet,"  
[http://www.adp.ca.gov/FactSheets/Drug\\_Medi-Cal\\_DMC\\_Minor\\_Consent\\_Services.pdf](http://www.adp.ca.gov/FactSheets/Drug_Medi-Cal_DMC_Minor_Consent_Services.pdf). (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, Drug Medi-Cal, "DMC Provider Resource Tool-Kit," [http://www.adp.ca.gov/dmc/dmc\\_resource\\_tool\\_kit.shtml](http://www.adp.ca.gov/dmc/dmc_resource_tool_kit.shtml) (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, Drug Medi-Cal, "DMC Provider Resource Tool-Kit Monitoring," [http://www.adp.ca.gov/dmc/dmc\\_drug\\_medical\\_monitoring.shtml](http://www.adp.ca.gov/dmc/dmc_drug_medical_monitoring.shtml) (accessed April 29, 2009).

<b>DRUG MEDI-CAL BILLING MANUAL</b>
Appendix G: Hyperlinks to Materials Referenced in this Manual

- Cal. Dept. of Alcohol and Drug Programs, "Fact Sheets," <http://www.adp.cahwnet.gov/Library/factsheets.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "HIPAA Privacy & Security," <http://www.adp.ca.gov/hp/hipaa.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Home Page," <http://www.adp.ca.gov> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Letter 97-54," <http://www.adp.ca.gov/ADPLTRS/pdf/97-54ex1.pdf> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Licensing," <http://www.adp.ca.gov/Licensing/index.shtml> (accessed April 29, 2009).
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- Cal. Alcohol and Drug Programs, "Negotiated Net Amount (NNA)," <http://www.adp.ca.gov/NNA/nnamain.shtml> (accessed April 29, 2009).
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- Cal. Dept. of Health Care Services, "Drug Medi-Cal," <http://www.medi-cal.ca.gov> (accessed April 29, 2009).
- Cal. Dept. of Health Care Services, "Medi-Cal, eLearning," <http://files.medi-cal.ca.gov/pubsdoco/eo/elearning.asp> (accessed April 29, 2009).
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<b>DRUG MEDICAL BILLING MANUAL</b>
Appendix G: Hyperlinks to Materials Referenced in this Manual

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